3M HEALTH CARE QUALITY TEAM AWARDS

Healthcare Quality

Team Initiatives

Executive Summaries

2020 Submissions

3M Canada Company
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Dear Dedicated Health Care Team Members,

In these unprecedented times, it has never been more apparent how crucially innovations in healthcare can impact our quality of life.

As always, healthcare professionals are tasked with the need to balance their adoption of new technologies and the need to improve patient outcomes with their obligation to provide the level of personal care that people need and deserve – all while dealing with the now ever-present threats that a global crisis has presented.

For this reason, 3M Canada is once again proud to have partnered with the Canadian College of Health Leaders for over two decades to recognize achievements in maintaining that balance even in times of crisis.

The 3M Health Care Quality Team Awards proudly recognize healthcare programs that improve the delivery of patient care and, by extension, the lives of our fellow Canadians. We thank you for once again letting us be a part of this event. These awards highlight the teams that work together on quality improvement projects resulting in sustained change within their organizations and, as in every previous year, the quality of the award submissions we receive make selecting a winner a difficult task.

Each team that took the time to share their initiatives deserves our congratulations and I want to thank all the nominees and winners for your efforts in moving healthcare in Canada forward. The enclosed booklet includes executive summaries of all the 2020 programs that were submitted for consideration. Despite the extraordinary times we are facing in healthcare, these initiatives prove that creative thinking, sharing best practices, and patient centered approach to care can dramatically improve the delivery of support and care across Canada. It also highlights the incredible partnership between 3M Canada and the Canadian College of Health Leaders.

The 3M Health Care Quality Team Awards provide a forum for all of us to celebrate these amazing accomplishments with the hope of creating systematic change.

As a science company, 3M Health Care values our partnerships with customers and industry stakeholders that allow us to provide solutions to health care professionals so they can focus on what is most important: their patients. Thank you for efforts to find ways to reduce complications, improve patient outcomes, and provide people with the care we receive and deserve.
We are proud to celebrate you all today.

Sincerely,

Drew McCallum

Drew McCallum, Division Leader
Medical Solutions Division, 3M Healthcare Business Group

In 1994, the Canadian College of Health Leaders and 3M Canada Company launched the 3M Health Care Quality Team Awards to encourage and recognize innovation in health services by linking two important concepts: quality and teams. Although two submissions were selected for special recognition, the 2020 competition included many important quality improvement efforts. We are pleased to share a brief overview of the submissions and hope this document will encourage wider use of quality planning methods and tools in Canadian health services.

2020 3M HEALTH CARE QUALITY TEAM AWARDS RECIPIENTS

- Quality Improvement Initiative(s) Across a Health System:
  Mackenzie Health - *Improving Stroke Outcomes Utilizing Data and Technology*

- Quality Improvement Initiative(s) Within an Organization:
  Island Health - *Prevention & Reduction of Open Heart Surgical Site Infections*

OTHER SUBMISSIONS:

Quality Improvement Initiative(s) Across a Health System

- Alberta Health Services - Edmonton Zone Home Care System Case Management Initiative
- Covenant Health - Transitions in Care
- Eastern Health - Cardiac Catheterization Laboratory
- Niagara Health - Paeds-TECH: Paediatric Telemedicine Connecting Hospitals/Niagara Health
- Orillia Soldiers' Memorial Hospital - Shared Birthing Program OSMH GBGH
- The Joint Department of Medical Imaging - JDMI Peer Learning Program Implementation
- William Osler Health System - Development of an Integrated Stroke Rehabilitation Model in the Central West LHIN - Community Outreach Stroke Rehabilitation (COSR) Program

Quality Improvement Initiative(s) Within an Organization

- Alberta Health Services - Edmonton Zone Facilitated Access to Surgical Treatment (EZ-FAST) Program
- Alberta Health Services - Provincial ICU Delirium Initiative
- Bluewater Health - Pharmacist Discharge Facilitator (PDiF)
- City of Lakes Family Health Team - Poverty Project
- Eastern Health - Chemotherapy Vial Optimization Project
- Eastern Health - Remote Patient Monitoring Expansion Project Team
- Hôpital Montfort - Involving patient partners in improving the flow of the surgery process
- Horizon Health Network - GAPSS: Gaps Analysis of Practice Standards in Stroke at the Stan Cassidy Center for Rehabilitation
- Horizon Health Network - Implementing an Open Access Booking Model for Outpatient Services
- Lumacare - Lumacare Client Centered Documentation
- Nova Scotia Health Authority - Redesigned integrated care pathways to support the health and wellness of newcomer population in Nova Scotia
- William Osler Health System - Patient-inspired Seamless Journey during All Phases of Health: Complex Medicine Clinic (CMC)
- William Osler Health System - Remote Self-Reporting of Symptoms for Palliative Patients (RELIEF) application

Improving Stroke Outcomes Utilizing Data and Technology

Mackenzie Health

Mackenzie Health's Stroke Team leveraged a multidisciplinary approach by utilizing EMR technology and data-driven process improvements as an enabler to achieve better functional outcomes for stroke patients. As a winning case - Improving Stroke Outcomes Utilizing Data and Technology - for the HIMSS Davies Award 2019, the Stroke Team demonstrated critical quality improvement initiatives focused on health system redesign in stroke care delivery. Customized electronic orders set improved clinical workflow for all team members in the hyperacute stroke process. Digital reports could be generated using standardized documentations, which provided the team with relevant and important analytics.

Data driven decision making processes combined with high stakeholder collaboration culminated in sustained results that could never have been achieved in a paper-based workflow. As a result of a series of incremental redesigns and optimizations that were implemented, time to Tissue Plasminogen Activator (tPA) administration (Door-to-needle, DTN time) was drastically reduced by 50% (53.5 minutes to 27 minutes) in an 18-month period Likewise, the time between patient arrival and when the left MH to be transported to an Endovascular thrombectomy (EVT) centre (Door-in-Door-out, DIDO time) significantly decreased from 97.5 minutes to 71 minutes, resulting in a 27% improvement. By reducing the DTN and DIDO times, the team saw improved patient outcomes and an overall estimated cost avoidance of $360,326 per year. Optimizing technology within the EMR allowed the team to gather important metrics to greatly improve and redesign workflow that ultimately improves patient outcomes.

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Prevention & Reduction of Open Heart Surgical Site Infections

Island Health

Island Health's Heart Health Program has catalyzed continuous quality improvement to reduce surgical site infections after open heart surgery in response to patient needs. The Heart Health Quality Management Team created a multi-disciplinary learning community to address infection rates and implement evidence-based standards. They collaborated to identify and agree on key data metrics and adopted REDCap, an innovative new data management tool that enables real-time data acquisition and reporting (not previously used for quality improvement). High-quality data and customized reports now meet the needs of all team members, and the system enables ongoing and rapid assessment of outcomes and immediate course corrections as required to provide the best possible care.

Due to their innovative, patient-led, and interdisciplinary approach, the team has improved patient outcomes and experience and enhanced sustainability by reducing organizational costs. Prior to this initiative, the infection rate per 100 procedures for all open heart wound infections was 7.7%, well above the national benchmark. In the first year of the initiative, that rate dropped to 2.7% and is currently at 2.3%. Before implementation, surgical site infections after open heart surgery cost Island Health nearly $900,000/year. After implementation, costs have been reduced to less than $400,000/year. The team has achieved results that will continue to improve over time through a learning health system model, converting relevant data to actionable knowledge that is immediately applied into clinical practice in a continuous cycle.

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Edmonton Zone Home Care System Case Management Initiative

Alberta Health Services

A key goal of Alberta's health system is helping people be as healthy, well and independent as they can be in their homes and communities. A cultural change, both within the traditional healthcare system, and within society in general, is required to achieve this goal. In the Edmonton Zone Home Care program, this cultural change is being achieved in large part through a systems case management approach, which addresses issues related to transitions and coordination of support for clients in the community.

In 2017, Alberta Health Services (AHS) began an initiative, Enhancing Care in the Community, to begin a shift to community health care and empower people to be as healthy, well and independent as possible in their homes. Edmonton Zone secured funding for the Home Care Program to develop a system case management approach to provide holistic and time sensitive support for clients and their families at critical junctures of their health care journeys. The initiative was key to the implementation of Destination Home to ensure that clients who may require placement after an Acute Care episode are supported to return home to restore functioning or are assessed at home for potential placement.

System case management recognizes that many times clients and their families require the services and support of multiple health services. During transitions between providers in particular, the ability of these services to coordinate is critical. System case management seeks to fill the gaps, provide comprehensive case management and ensure time sensitive services are provided.

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Transitions in Care

Covenant Health

The Transitions in Care project was a pilot initiative within Covenant Health to help patients transition smoothly from acute care to the community setting. The team behind this initiative was focused on developing and testing an intervention for early identification of complex patients at risk for readmission, and promote patient centric, targeted discharge planning with intentional connections to community supports (such as primary care physicians and medical monitoring post discharge). By doing so, the team sought to improve how patients transition from acute care back to the community, increasing a seamless journey from home to hospital to home.

Tools utilized included the LACE screening tool and a post-discharge phone call. The use of the LACE tool on charts highlighted the complexity of patients to interdisciplinary teams, thereby decreasing patient's length of stay by an average of 4 days. While the post-discharge phone call did not have an impact on readmission in the short term, it did identify other barriers to a smooth transitions home for patients, such as problems with picking up needed equipment to support care at home. The pilot also highlighted cross sectorial areas for future improvements that would impact patient's transitions out of care.

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Cardiac Catheterization Laboratory

Eastern Health

Eastern Health's cardiac catheterization laboratory (cath lab) in St. John's had been struggling with substandard utilization levels, long wait lists and resulting employee stress and burnout. Using Lean Six Sigma process improvement methodology combined with principles of value-based health care, consultants worked closely with all levels of Eastern Health management and staff to understand and resolve the root causes of the cath lab's challenges.

Within the first two months of launch, utilization in the cath lab had increased by 37 per cent, and by January 2019, average wait times for inpatients had dropped by between 44 and 72 per cent (depending on the health region) compared to the previous fiscal year. Current data indicates that improved value continues to be present one year after implementation, by as much as 48%. The impact on staff morale has been equally dramatic. Team members have regained a sense of pride in what they can accomplish for patients, turnover has decreased, and employee engagement scores are substantially higher.

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Paeds-TECH: Paediatric Telemedicine Connecting Hospitals/Niagara Health

Niagara Health

Niagara Health (NH) is a regional healthcare provider with multiple sites and a growing network of community-based services. Our team is made up of more than 4,800 employees, 600 physicians and 850 volunteers who we count on to deliver extraordinary caring to every person, every time. As a community-based academic centre, teaching and learning, research, innovation and partnership are propelling us as we imagine a healthier Niagara.

Across the NH, paediatric emergency services are provided at three Emergency Departments (ED) and two Urgent Care Centres (UCC). However, there are instances when acutely ill patients present to one of our sites and require a specialized, advanced paediatric skill level that is not available in the region. Although rare, when these critical cases present, they require fast-paced, specialized care to ensure best outcomes and stabilize the patient for transfer to a tertiary paediatric center. To address this gap in access to specialized paediatric services in the Niagara region, a partnership between NH, McMaster Children's Hospital (MCH) and the Ontario Teleresuscitation Network (OTN) was created, and team members worked collaboratively to develop and implement a paediatric teleresuscitation network, the Paeds-TECH project. This care network, launched in December 2018, is the first of its kind in Ontario. Since going live, eighteen paediatric cases have benefitted from this system, which links local physicians to emergency paediatric specialists at MCH and allows the teams to remotely work together.

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Shared Birthing Program OSMH GBGH

Orillia Soldiers' Memorial Hospital

After an external review and the retirement of the sole obstetrician, GBGH was left facing the threat of closure of birthing services at Georgian Bay General Hospital in late 2015. The community was vocal about the need to rethink outright closure of the service and a committee was struck to research and consider alternatives, led by Dr. Keith Rose. The GBGH Board decided to consider a partnership strategy to create a sustainable future for the program. The unique patient population including Francophone and First Nations communities, coupled with geographic realities and challenges for travel highlighted the need for continued local services.

Building on longstanding close working relationships, GBGH and OSMH committed to work in partnership to support access to birthing services for the communities of Midland, Penetanguishene, Tiny, Tay, Springwater and Christian Island.

In 2017, GBGH and OSMH formalized an agreement to offer joint birthing services across North Simcoe. In this partnership, GBGH provides low-risk birthing services in Midland, while higher-risk births are transferred to OSMH. There is a comprehensive process to assess and direct mothers to the appropriate centre for labour and delivery of their babies.

The teams created a shared vision for the Shared Birthing Program, "A regional program that delivers high quality, safe, appropriate, timely and seamlessly coordinated care and services by a collaborative team of well-trained health professionals at two sites to meet the birthing, neonatal, obstetrical and gynecological needs of the two communities, including marginalized populations."

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JDMI Peer Learning Program Implementation

The Joint Department of Medical Imaging

In medical imaging, the accuracy of a patient's diagnosis is dependent largely on two things: the quality of images that the technologist produces and the interpretation of images by the radiologist. Amidst pressures of meeting increasing demand for services, it can be challenging for medical imaging departments to maintain a consistent focus on quality. For a large health system such as the Joint Department of Medical Imaging (JDMI), ensuring that patient exams are delivered with the highest quality of care has always been a core strategic priority.

The JDMI Peer Learning Program for Radiologists and Medical Radiation Technologists is an innovative quality improvement program that harnesses the power of collaboration and technology to enable a focus on continuous improvement by bringing staff together around data to collectively identify opportunities to improve the delivery of patient care. JDMI's unique approach to peer learning, which combines a user-friendly IT solution developed in-house, Coral Review, paired with defined quality accountabilities and structures, has strengthened JDMI's culture of continuous quality improvement.

JDMI has demonstrated success in expanding the program internally as well as in taking our learnings and supporting colleagues from across the country and beyond to learn from each other and deliver the highest quality of imaging and care for our patients. JDMI is leading change in the field of medical imaging by focusing on what patients need most: a reliable, patient-centered system that can evolve with the latest technologies in order to deliver exceptional care and contribute to a healthier world.

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Development of an Integrated Stroke Rehabilitation Model in the Central West LHIN - Community Outreach Stroke Rehabilitation (COSR) Program

William Osler Health System

Timely access to therapy following a stroke is extremely important for positive outcomes. However, within the Central West Local Health Integration Network (LHIN) there were a lack of integrated stroke rehabilitation services, and acute care lengths of stay for patients that exceeded best practice recommendations for mild stroke. Discharged patients would also wait for outpatient therapy for up to 24 weeks, with limited opportunities for home care. In 2018, William Osler Health System collaborated with partners - 1 to 1 Rehab, West GTA Stroke Network, and the Central West LHIN Home and Community Care - to create the Community Outreach Stroke Rehabilitation (COSR) Program. COSR uses an integrated approach to provide high quality care for patients as they transition from hospital to community, and improves patient flow through the hospital. The cross-continuum collaboration meant a new service model where members from acute care, hospital outpatient and home care work as one care team, regardless of employer. Based on patient needs and goals, care was provided in a clinic, home, or community setting.

This process reduced the number of patients waiting for services and also requiring hospital admission. Those who were admitted returned home sooner. The results have had significant impact on patient experience and the partners won a Central West LHIN Quality Award after the unique approach resulted in 100 per cent satisfaction. Given the high value to patients, Osler invested in resources at the conclusion of the pilot to maintain the program on an on-going basis.

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Edmonton Zone Facilitated Access to Surgical Treatment (EZ-FAST) Program

Alberta Health Services

The Edmonton Zone Facilitated Access to Surgical Treatment (EZ-FAST) Program is a centralized referral program for general surgical consultation in the city of Edmonton, Alberta, which has provided care to over 17,500 patients since its inception. The program has transformed how we provide surgical consultation to our patients, and has proven to be highly effective in improving access to surgical care and increasing the efficiency of surgical consultation. Implementation of the program has allowed us to achieve a significant, sustained improvement in access, reducing the median wait time for surgical consultation by 80 days (140 days to 60 days).

The program utilizes a pre-consultation screening service which has allowed us to divert up to 75% of patients into non-surgical treatment. The program has proven to be popular with both referring physicians and specialists, and has rapidly expanded to include 48 general surgeons at six hospitals, and over 1000 family doctors in 14 Primary Care Networks. The EZ-FAST program has also led to closer, more collaborative relationships within our surgical group and between surgeons and family doctors, and has allowed all stakeholders to work together to overcome challenges for our patients. In addition, the program has enabled us to drive further process improvement projects such the reduction of waiting time for endoscopy services. We believe the model we have developed is sustainable and can be replicated by other surgical services. In the coming months, the program will expand to include additional hospitals and services in Alberta.

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Provincial ICU Delirium Initiative

Alberta Health Services

The Provincial ICU Delirium Initiative is a strategic best practice implementation initiative led by the Critical Care Strategic Clinical Network (CC SCN) in collaboration with front line staff and physicians, patients and families, and implementation teams in all 17 adult and 3 pediatric ICUs across Alberta to implement best practices to prevent and manage ICU delirium. Establishing and implementing a standardized, evidence-based, provincial approach to ICU delirium care for all critically ill patients resulted in improved patient outcomes, and significant changes to clinical practice.

Key achievements include:

- Improved patient outcomes through a 10% reduction in the number of days patients experience delirium.
- Sustained practice; 90% of all adult patients are screened for delirium every day.
- Adopted and implemented delirium screening for children in ICU; resulting in a 52% increase in daily screening.
- Improved patient and family experience by co-designing patient and family-centred resources focused on ICU delirium.
- Created an estimated $5.2 million in value for the health system by reducing the impact of delirium on patients. Value is driven by shorter duration of ventilation, lower pharmaceutical use, fewer laboratory and diagnostic imaging tests, and reduced use of consumable supplies.
- Established a provincial collaborative community for adult and pediatric critical care focused on quality improvement, evidence and use of data to regularly measure performance and patient outcomes.

The successes of this program and implementation demonstrate the benefits of a single provincial health authority, and Alberta Health Services can learn from this implementation to further improve the system.

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Pharmacist Discharge Facilitator (PDiF)

Bluewater Health

The Bluewater Health Pharmacy program has developed a new pharmacist role called the Pharmacist Discharge Facilitator (PDiF) to improve patient safety and satisfaction at the discharge transition of care. A pharmacist is available to help with patient counselling on discharge from hospital. The focus is on educating patients on effective and safe medication use to avoid adverse events and improve patient safety at discharge. A PDiF pharmacist and a Doctor of Pharmacy student cover discharges on four inpatient floors totalling 100 inpatient beds during the weekdays.

A referral system is in place to target high risk patients. In the calendar year of 2019, the PDiF team was involved in the care of 1367 patients which is roughly 53% of all discharges on those four nursing units. A total of 1075 patients were seen face to face and an additional 292 patient charts were clinically reviewed but not seen by a discharge pharmacist. The average time spent per patient discharge was 29 minutes. A total of 189 clinically significant discharge events were identified and resolved prior to discharge. These typically include:

- missing medications on discharge
- unnecessary drug therapy
- requiring a different product,
- medication dose too high or dose too low,
- adverse drug reaction,
- adherence concerns and affordability issues.

Feedback from staff and patients has been positive. A patient satisfaction survey showed that 99% of patients agreed or strongly agreed that the discharge pharmacist helped them to understand the intended use of their medication and how to take it safely and correctly

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Poverty Project

City of Lakes Family Health Team

According to the Canadian Medical Association, 50% of population health is determined by the social and economic environment. Clinical leaders at the City of Lakes Family Health Team in Sudbury, Ontario, knew that their capacity to affect the chronic health issues of many of their patients could not be adequately addressed if they did not attend to the underlying social determinants that impacted their lives. Data indicated that 24% of their patients screened had difficulty making ends meet. They recognized the need and the importance of these determinants, specifically poverty, but were exasperated by the lack of resources, time and seamless connections to existing community resources and social services.

The fundamental innovation of the Poverty Project was to equip clinicians with the tools, resources and interventions necessary to affect a shift in how they addressed poverty. There were several quality improvement objectives of the Poverty Project: increase awareness of health inequity and poverty across the team; educate clinical providers as to how they could support patients with income security issues; develop a mechanism for identifying patients struggling to make ends meet; engage patients to better understand their needs; develop an internal organizational capacity to easily connect patients to community services and resources; and track progress.

This project demonstrated that primary care not only has a role in addressing the social determinants of health but, through a collaborative leadership approach and a intentional cultural shift, providers can build it into the way that they work every day.

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Chemotherapy Vial Optimization Project

Eastern Health

The National Association of Pharmacy Regulatory Authorities (NAPRA) Model Standards for Pharmacy Compounding of Hazardous Sterile Preparations mandate that single use vials of chemotherapy must be discarded by six hours after initial needle puncture, due to theoretical risk of microbial contamination.

Measurement of the quantity and value of chemotherapy vials discarded at the Health Sciences Center, Eastern Health's largest tertiary care facility, revealed adhering to this standard restricts the number of patients than can be treated per vial, and costs the organization over $600,000 in wasted chemotherapy annually. The NAPRA Standards represent the minimum requirements to be applied in compounding sterile products such as chemotherapy to ensure quality and safety, and are enforced by the provincial pharmacy regulatory authority, the Newfoundland and Labrador Pharmacy Board (NLPB).

Acknowledging these standards, the Chemotherapy Vial Optimization project goal was to reduce the value of chemotherapy waste without compromising the quality and safety of chemotherapy drugs compounded by the Health Sciences Center pharmacy or quality of care received by its patients. Further, practice changes resulting from the Chemotherapy Vial Optimization project had to be acceptable to the NLPB, as well as internal stakeholders.

Achieving reductions in chemotherapy waste supports cancer system sustainability and facilitates patient access to cancer therapies, by enabling conservation of drug supply during chemotherapy drug shortages as well as through reinvestment of savings in novel chemotherapy drugs.

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Remote Patient Monitoring Expansion Project Team

Eastern Health

The Remote Patient Monitoring (RPM) Expansion Project was initiated in 2017 to further support Eastern Health's vision of Healthy People, Healthy Communities and to support its strategic plan. Access to care and Population Health are just two of the strategic priorities which the RPM program addresses.

RPM is a patient-centric model of care which utilizes innovative technology to support patients with chronic disease in their self-management journeys. By partnering with patients in goal-setting, and providing coaching, education and monitoring, patients are empowered and become experts in their own care – regardless of their geographical location.

In building the RPM program, clinicians were engaged in providing input into building content using evidence-based practice. As a core stakeholder to the RPM Program, the patient perspective was collected through interviews and focus groups. Ongoing feedback is elicited from patients and used in quality improvements. A Patient Safety and Quality Forum was held to enhance this involvement and a there is a patient partner involved fully with the project.

A key component of the success of the program was the strong and enthusiastic team dynamic which drove success and positive patient outcomes.

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Involving patient partners in improving the flow of the surgery process

Hôpital Montfort

Montfort is Ontario's Francophone Academic Hospital, offering exemplary person-centred care to over 1.2 million people in Eastern Ontario, in both official languages.

Montfort has been a true believer in the Lean methodology since 2008, starting with the Emergency and Medicine departments. More recently, the hospital's Lean efforts turned to surgery in hopes of improving patient experience.

In 2014, Montfort started to involve patient partners in the process of reviewing (and revolutionizing) the flow of the surgery process, as part of the hospital's advanced Lean practices.

With this specific patient partner initiative, our ultimate objective was that during the entire surgery process, "the patient (would) no longer wait uselessly".

This challenging goal was propelled by one of our patient partners' personal experiences.

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GAPSS: Gaps Analysis of Practice Standards in Stroke at the Stan Cassidy Center for Rehabilitation

Horizon Health Network

The GAPSS project has introduced an interdisciplinary approach to implement evidence-based best practice standards, overcoming many well-known barriers and challenges, including personal, organizational and cultural. The implementation of best practice standards ensures that care delivered by the team is safe and of the highest quality. The team leader guided a knowledgeable and dedicated team of professionals through this process with enthusiasm over a 2-year period. She optimized the skills of all of those around her, accessing pre-doctoral interns, university research students and colleagues to gather information, analyze and evaluate the findings. She trained the entire team on the use of an innovative, yet simple communimetrics rating system that allows each rehabilitation discipline to evaluate the applicability of the standard to their practice (tertiary neurorehabilitation), the current adherence to the standard and the priority rating of that standard to the team.

Over 1000 standards were reviewed, evaluated and prioritized by the team then were addressed through concrete action plans. The team leader equipped the team with a method to undertake the extremely daunting task of looking at complex and lengthy clinical best practice standard documents for any diagnostic group. The team could apply a logical, systematic methodology to evaluate whether the team is complying with the standard, if the team should be and what the team will do to meet the standard. This work ensures that the care that is provided by the team to our clients and their families is the safest, highest quality care.

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Implementing an Open Access Booking Model for Outpatient Services

Horizon Health Network

The Open Access Booking (OAB) project was designed to improve the patient and family experience when accessing outpatient therapeutic services. Traditional appointment booking processes are labour-intensive, require significant wait-list management, and are non-value added for the patient. Traditional models continue within the organization. A change management plan was created to assess barriers, challenges and the desire to change the current process. Physicians were engaged to modify their current referral practice, innovative solutions were found to deal with current waitlists, staff schedules were revised, and new booking processes were designed and implemented.

Meanwhile, the project team was diligent in implementing a practice that adhered to their philosophy of responding to what the patient wants: to receive an appointment when they call. Patient's were involved during each phase of the project, ensuring their knowledge and experience impacted the final product. Patients are empowered to participate in their health care which has resulted in improved patient satisfaction as they immediately receive an appointment and are no longer on a waitlist. Other achievements are a reduced number of patients not showing up for their appointment, reduced workload to book appointments and increased availability of appointments.

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Lumacare Client Centered Documentation

Lumacare

Lumacare Client Centered Documentation markedly improved the quality of documentation of client files within the organization. The initiative resulted in the development of a sustainable practice of high-quality documentation. The organization developed templates on how to collect information from clients for client-facing staff. It also devised a Lumacare audit documentation tool that was used to assess the data collected. The organization developed training for documentation and revised roles and policies to incorporate the importance of accurate documentation.

Furthermore the initiative also resulted in an initial assessment tool that the client navigators use to assess potential clients today. After protocols, practices and training were put in place for documentation, there was an average score increase of 72.6 to 84.6 in the audit score. The amount of "High Quality" (defined as documents that had an audit score of 75 and above) Notes has Improved from 34% to 71%. Clients and caregivers reported satisfaction in the new processes set in place for accurate documentation and were pleased with the quality of the documentation. Many were unaware that they had the right to request their files before this initiative commenced. It empowered them to be involved in part of the initiative that helped create a process in Lumacare for high-quality documentation of their files.

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Redesigned integrated care pathways to support the health and wellness of newcomer population in Nova Scotia

Nova Scotia Health Authority

Newcomer Health Clinic (NHC) in Primary Health Care, Nova Scotia was established in 2014 to meet primary care needs for refugees and refugee claimants. The model is based on the Beacon Clinic Model to support temporary primary care needs for newly settled refugee populations. The NHC team has organized its functions, operations and care around the complex needs of this patient population. Patient needs have increased support for health promotion and prevention strategies, including care transitions that promote access to a permanent primary care provider. In this submission, the team describes the NHC improvement initiative to address these needs through integrated care pathways.

NHC team providers, administrative staff and key partners, including patients and families, worked collaboratively to identify and design an approach to ensure access to care that promotes health promotion and prevention while managing a complex needs population. The quality improvement initiative included engaging, training and educating key partners including community-based family physicians and primary care providers. This has led to two key areas of process improvements and redesign: specialized clinics that enhance prevention, screening and health promotion; and, improved access to primary care. Outcomes include improved access to health promotion and enhanced experience of care. Sharing this work locally and nationally is a key next step.

NHC efforts demonstrate the success – and need – for the clinic. NSHA proudly supports the nomination of Redesigned integrated care pathways to support the health and wellness of newcomer population in Nova Scotia to the 3M Health Care Quality Team Awards program.

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Patient-inspired Seamless Journey during All Phases of Health: Complex Medicine Clinic (CMC)

William Osler Health System

The Central West Local Health Integration Network (LHIN) continues to experience unprecedented Emergency Department visits and have large percentages of patients with two or more acute inpatient admissions within 28 days post discharge. In 2016, Osler launched its Complex Medicine Clinic (CMC) at the Peel Memorial Centre for Integrated Health and Wellness as an integrated approach to provide care for patients. The CMC is a Nurse Practitioner-led outpatient model that manages patients, in an inter-disciplinary setting, who have experienced multiple, recent ED visits and / or inpatient hospitalizations. This service enables improved collaboration between acute, specialty and primary care through a “hub and spoke” model of care.

Through this clinic, subsequent ED visits and inpatient admissions have been reduced as patients have a place for interdisciplinary follow up care. Post enrollment in CMC, ED visits were reduced by 34% and inpatient admissions by 43%, compared to a 6-month period prior to enrollment. Patient and caregiver satisfaction has improved with the ‘one-stop’ care model.

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Remote Self-Reporting of Symptoms for Palliative Patients (RELIEF) application

William Osler Health System

Due to unprecedented growth and demand for services, assessments of pain and symptoms for palliative patients may take weeks. This represents a gap in knowledge of patient's symptom status, and delayed interventions, and often results in Emergency Department (ED) visits and hospital admissions. Although the majority of Canadians die in hospital, most palliative patients would prefer to experience end of life care in their homes.

Osler's Remote Self-Reporting of Symptoms for Palliative Patients (RELIEF) application was designed to capture patients' daily symptoms from the comfort of their homes. With this real-time data patient status is monitored and triaged daily, enabling clinicians to proactively respond to deteriorating conditions, reducing patient distress, maintaining patient independence, and preventing unnecessary and uncomfortable ED visits. With earlier intervention, community palliative care resources can be appropriately mobilized, and timely recommendations can be made for urgent connection to Osler's palliative care services. This allows for improved patient experiences, all while achieving better system integration, and efficient utilization of resources.

Patient and family input was also utilized in the development of the application. By empowering patients and providing a virtual option to care, patients, caregiver and provider satisfaction improved. With 80% of enrolled patients able to participate in the application, feedback was overwhelmingly positive. The application can be easily translated and adapted by other agencies by simply downloading it.

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Former Team Award Recipients

Quality Improvement Initiative(s) Within an Organization

2019 – Providence Health Care
Megamorphosis: Shifting from an Institutional to a Social Model in Residential (Long-Term) Care

2018 - Primary Health Care
"Getting the Care I Need, When I Need it": Group Visits Empower Changes in Priority Areas across Primary Health Care System

2017 – University Health Network (UHN)
UHN Quality Improvement Plan Discharge Summary Program

2016 – Mississauga Halton LHIN
Weaving a Mosaic of Support: Caregiver Respite in Mississauga Halton LHIN

Quality Improvement Initiative(s) Across a Health System

2019 – North York General Hospital
Breast Cancer Integrated Care Collaborative

2018 – Trillium Health Partners
Putting Patients at the Heart: A Seamless Journey for Cardiac Surgery Patients

2017 – London Health Sciences Centre
Connecting Care to Home (CC2H)

2016 – BC Cancer Agency and Provincial Health Services Authority
Get Your Province Together! BC Cancer Agency Emotional Support Transformation

Programs and Processes in an Acute Care Hospital Environment

2015 – St. Paul's Hospital, Providence Health Care
Evolving Care Systems: The hemodialysis renewal project, a co-location model for change

2014 – Mount Sinai Hospital
The Acute Care for Elders (ACE) Strategy

2013 – Vancouver Coastal Health
iCARE/ITH: One Integrated Model of Care

2012 – North York General Hospital
e-Care Project

2011 – St. Michael's Hospital
Inspiring Improvement: Working Together for Timely, Quality Patient Care at St. Michael's Hospital

2010 – IWK Health Centre
Twenty-four Hour Dial for Dining Program

2009 – Trillium Health Centre
Creating Excellence in Spine Care – Re-designing the Continuum

2008 – North York General Hospital
Patient Flow: Improving the Patient Experience

2007 – University Health Network (UHN)
ED-GIM Transformation Project

2006 – Providence Health Care
Improving Sepsis Outcomes

Acute Care Facilities

2005 – St. Paul's Hospital
Living PHC's Commitment to Excellence: The "LEAN" Approach to Quality Improvement in the Laboratory

2004 – Providence Health Care
A Multidisciplinary Pathway for Surgical Patients from First Hospital visit to Discharge

2003 – Trillium Health Centre
Driving Performance Excellence at Trillium Health Centre: The Dashboard as a Catalyst for Change

2002 – Trillium Health Centre
Ambulatory Care That Takes Quality to the Extreme

Large/Urban Category

2001 – The Scarborough Hospital
A Change of Heart: Innovative Care Delivery for the CHF Patient

2000 – Rouge Valley Health System
Pediatric Clinical Practice Guidelines: Providing the Best for Our Children

1999 – Sunnybrook & Women's Health Science Centre
Long-Term Care Work Transformation Project

1998 – Scarborough General Hospital
Orthopaedic Future: Making the Right Investments

1997 – St. Joseph's Health Centre
Dialyzer Re-use: An Advance in the Cost and Quality in the Canadian Healthcare System of the 1990s

1996 – London Health Sciences Centre

1**995 – Tillsonburg District Memorial Hospital**

1994 – Renfrew Victoria Hospital

Programs and Processes in a Non Acute Environment

2015 – Capital Health
My Care My Voice: ICCS Initiative to Improve Care for Complex Patients by Providing a "Voice to the Patient"

2014 – Island Health
Better Patient Journeys: Community-Lead Strategies to Improve Hospital Flow

2013 – Capital Health, QEII Health Sciences Centre
Palliative and Therapeutic Harmonization: Optimal Care, Appropriate Spending

2012 – Alberta Health Services
Glenrose Rehabilitation Hospital Services Access Redesign

2011 – Mississauga Halton Local Health Integration Network
Support for Daily Living Program – A Winning Community-based Solution for Addressing ED, ALC and LTC Pressures

2010 –Sunnybrook's Holland Orthopaedic & Arthritic Centre
A Team-based Approach to Chronic Disease Management That Improves Patient Access and Care

2009 – Whitby Mental Health
Whitby Mental Health Metabolic and Weight Management Clinic

2008 – Capital Health
Implementation of Supportive Living Integrated Standards

2007 – Providence Health Care (PHC)
Medication Reconciliation: Reducing the Risk of Medication Errors for Residents Moving in to Residential Care

2006 – Maimonides Geriatric Centre
Minimizing Risk of Injury

Other Facilities/Organizations

2005 – Capital District Health Authority
Organ and Tissue: Innovation in Donation

2004 – Vancouver Island Health Authority
Implementing the Expanded Chronic Care Model in an Integrated Primary Care Network Project

2003 – St. John's Rehabilitation Hospital, Toronto Rehabilitation Institute
Achieving Clinical Best Practice in Outpatient Rehabilitation: A Joint Hospital-Patient Satisfaction Initiative

2002 – Maimonides Geriatric Centre
Maimonides Restraint Reduction Program

Small/Rural Category

2001 – Woodstock County General Hospital
Endoscopic Carpal Tunnel Release: An Example of Patient-Focused Care

2000 – Welland County General Hospital – Niagara Health System
Niagara Health System: Patient-Focused Best Practice Program

1999 – Headwaters Health Care Centre
Teamwork Key to Quality Care: Filmless Digital Imaging System Addresses Quality Issues for Patients, Hospital, Medical Staff and Environment

1998 – Alberta Capital Health Authority
Castle Downs Health Centre

1997 – Brome-Missisquoi-Perkins Hospital
Client-Centred Approach to Care Surgery Program

1996 – Crossroads Regional Health Authority
Pharmacy/Nursing Team Summary

1995 – Centenary Health Centre

1994 – The Freeport Hospital Health Care Village

Summary

Descriptions provided by the entrants indicate that quality teams empower employees by giving them knowledge, motivation and a strong sense of ownership and accountability. Multidisciplinary teams, united for a common purpose, achieve results that no one person, department or service can. By transcending departmental boundaries and learning about each other's functions, teams found workable solutions to organizational problems. This, in turn, enabled them to function as internal consultants and models for continued improvement. They developed healthy interprofessional relationships among themselves, other departments and the community. By setting up teams, organizations observed that management decision making became team-based decision-making; single assessment and evaluation turned into team assessment and evaluation; a focus on technical skills became a focus on process management skills; a focus on individual skills became a focus on the ability to be on a team; and subjective/intuitive evaluation became objective, evaluative tools.

The College and 3M Health Care are looking forward to receiving many new and innovative team initiatives for consideration for next year's 3M Health Care Quality Team Awards.

The details and the entry form are available on-line at www.cchl-ccls.ca. For further information, please contact:

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Canadian College of Health Leaders

The Canadian College of Health Leaders (CCHL) is a national, member-driven, non-profit association. The College strives to provide the leadership development, tools, knowledge and networks that members need to become high impact leaders in Canadian healthcare.

As defined by the LEADS in a Caring Environment framework, a leader is anyone with the capacity to influence others to work together constructively. The College's LEADS Canada team provides LEADS-based leadership development services, and partners with organizations, authorities and regions to facilitate not only the adoption of the framework, but a cultural shift required to fully imbed LEADS throughout an organization.

Through LEADS, the CHE designation, credentialing, training, conferences, mentoring and a nationwide careers network, we support health leaders in every sector and region, from every professional background and at any stage of their career.

Located in Ottawa, the College collaborates with 20 chapters across the country and engages with its 3,700 members and 70 corporate members to promote lifelong learning and professional development while recognizing leadership excellence.

Visit www.cchl-ccls.ca for more details. Follow us on Twitter @CCHL_CCLS and on Facebook at https://www.facebook.com/CCHL.National/.

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